



BURLINGTON

Healthcare Providers, LLC

PROFESSIONAL LIABILITY INSURANCE APPLICATION (Locum Tenens)

I. APPLICANT INFORMATION

Name: _____

Principal Business Address: _____

Phone: _____ Fax: _____

Residence Address: _____

Phone: _____ Email: _____

Birth Date: _____ Birth Place: _____

Citizenship: _____ Social Security No: _____

II. APPLICANT EDUCATION AND TRAINING

THIS SECTION CAN BE LEFT BLANK IF APPLICANT HAS INCLUDED A CURRICULUM VITA (CV) WITH COMPLETE EDUCATION AND TRAINING INFORMATION.

1. Schools.

<i>Undergraduate College/University</i>	<i>Degree</i>	<i>Graduation Date</i>
_____	_____	_____
_____	_____	_____

Medical School

Other Professional Training:

2. Internships.

Institution Name: _____

Complete Address: _____

Type of Internship: Rotating _____ Special _____

Other: _____ from _____ to _____

If more than one internship was begun or completed, please supply the details as above on a separate sheet and attach to the application.

3. Residencies.

Institution Name: _____

City/State/Country: _____

Type of Residency: _____ from _____ to _____

If more than one residency was begun or completed, please supply details as above on a separate sheet and attach to the application.

4. Fellowships.

Institution Name: _____

Complete Address: _____

Type of Fellowship: _____ from _____ to _____

If more than one fellowship was begun or completed, please supply details as above on a separate sheet and attach to the application

List all states in which you have held a license to practice medicine and your current licensure status:

State:	License No:	Status:
_____	_____	_____
State:	License No:	Status:
_____	_____	_____
State:	License No:	Status:
_____	_____	_____
State:	License No:	Status:
_____	_____	_____

Board Certification.

a) List names of specialty boards by which you are certified:

_____	Date:
_____	Date:

b) If not certified, have you applied for certification examination?

Yes _____ No _____

If “yes”, indicate which boards and the dates you are scheduled to take the certification examination?

Date:	Board
_____	_____
Date:	Board
_____	_____

III. PROFESSIONAL LIABILITY INFORMATION.

1. Have any disciplinary actions been initiated or are any pending against you by any state licensure board? Yes _____ No _____
2. Has your license to practice medicine in any state ever been denied, limited, suspended, or revoked? Yes _____ No _____
3. Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal, or state health insurance program (for example, Medicare, Medicaid)? Yes _____ No _____

4. Has your controlled substance registration ever been limited, suspended or revoked?
Yes _____ No _____
5. Has your professional liability insurance coverage ever been terminated by action of the insurance company?
Yes _____ No _____
6. Have you ever been denied professional liability insurance coverage?
Yes _____ No _____
7. Have any professional liability suits ever been filed against you, including suits which were subsequently dropped?
Yes _____ No _____
8. Have any professional liability suits been filed against you which are presently pending?
Yes _____ No _____
9. Have any judgments or settlements been made against you in professional liability cases?
Yes _____ No _____
10. Have you ever been the subject of any administrative, civil or criminal complaint or investigation regarding sexual misconduct?
Yes _____ No _____
11. Have any of your medical staff appointments or clinical privileges ever been suspended, diminished, revoked, refused or limited at any hospital or other health care facility?
Yes _____ No _____
12. Have you ever been convicted of a crime (other than a traffic offense) or are you currently under indictment for an alleged crime?
Yes _____ No _____

If you answered "yes" to any of the above questions, provide a full explanation on a separate sheet and attach to the application.

IV. HEALTH STATUS.

1. Date of last physical examination: _____
2. Have you been hospitalized any time during the past five years?
Yes _____ No _____

REFERENCES for (dr.'s name here), M.D.

Please list at least three professional references, not including relatives, who have had the opportunity to work closely with you within the last 2 years. Please provide current and complete addresses and phone numbers. These individuals will be contacted and asked to complete a reference over the phone.

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

SUPPLEMENTAL CLAIM INFORMATION

Answer all questions completely.

(PLEASE TYPE OR PRINT)

Full name of Applicant: _____

Full name of individual(s) of firm involved in the claim: _____

Full name of Claimant: _____

Sex: _____

Age: _____

- Was claim or suit merely threatened, or
 Limited to claimant's attorney contact (e.g., request of medical records), or
 Actually filed against you?

Date of alleged error: _____

Date of claim: _____

Additional defendants: _____

Disposition of claim: (✓ check box)

- DISMISSED (Action dropped without any payment to claimant or Statue of Limitations has expired)
 ABANDONED (No activity from claimant for over 3 years)
 WON by defense
 WON by claimant. Total paid \$ _____

Indicate whether

- a) Court judgment, or \$ _____
 b) Out of court settlement \$ _____

OPEN (Provide the following):

- a) Claimant's settlement demand? \$ _____
 b) Defendant's offer for settlement? \$ _____
 c) Insurer's loss reserve \$ _____
 d) Name of Insurer: \$ _____

Description of claim (*Provide enough information to allow evaluation*):

1. Alleged act, error or omission upon which Claimant bases claim:

2. Description of case and events:

Diagnosis:

Prognosis:

3. Type of injury claimed:

- Emotional Only Temporary Disability Death
 Cosmetic Permanent Disability Other (describe)

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same warranty and conditions.

Signature of Applicant:

Date:

PHOTOCOPY THIS FORM AND SUPPLY US WITH SEPARATE INFORMATION FOR EACH CLAIM, SUIT OR INCIDENT

RELEASE & AUTHORIZATION:

In making an application to Burlington Healthcare Providers (BHP), I certify that the information and supporting documents I have provided to BHP is true and accurate and that it may be used by BHP for evaluating my potential as a Locum Tenens Physician, and that BHP will rely on the truthfulness of my application.

With regard to this application, I authorize Burlington Healthcare Providers and its representatives to obtain any information that may be relevant to an evaluation of my professional qualifications, including information about disciplinary actions or other credentials or confidential information.

I hereby release from liability Burlington Healthcare Providers, its officers, employees, and representatives, and third parties who provide or receive information regarding my credentials in good faith and without malice. Further, I agree to indemnify, defend and hold Burlington Healthcare Providers harmless, from any and all claims, causes of action, damages, judgments and expenses, arising from or related to the collection, verification and dissemination of my credentialing information.

I understand that I have the burden of providing accurate information to Burlington Healthcare Providers to demonstrate my qualifications and that any misrepresentation on this application may constitute grounds for canceling my assignments.

I understand that I am responsible for notifying Burlington Healthcare Providers of any changes affecting my professional status.

I understand that the decision to refer me to Burlington clients is at the discretion of Burlington Healthcare Providers.

I understand the information provided by references is confidential and will not be released to me without the consent of the reference.

(APPLICANT'S SIGNATURE)

DATE:

INDEPENDENT CONTRACTOR STATEMENT

Date

Name, M.D.

Street

City, State Zip

I, Name, M.D., am reimbursed as an independent contractor. I further agree to abide by the guidelines of the IRS regarding payment of all taxes, FICA, and other payments due the state and federal government as outlined for an independent contractor.

Name, M.D.

Social Security Number/Tax ID #

(Date) _____